Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS5462AGC	A. BUILDING _____ B. WING _____	01/09/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SWEET HOME BELMONT LLC	2908 BELMONT DR HENDERSON, NV 89074

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments The survey was conducted using Nevada Administrative Code (NAC) 449, Residential Facility for Groups Regulations on 9/12/2008, adopted by the Nevada State Board of Health on July 14, 2006. This Statement of Deficiencies was generated as a result of the initial State Licensure survey conducted at your facility on 01/09/2009. The facility has applied for a license as an 8 bed Residential Facility for Group which provides care for Elderly or Disabled Adults, Category II residents. The census at the time of the survey was zero (0) residents. One (1) sample resident file was reviewed and two (2) employee files were reviewed. There were no complaints investigated during the survey. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. No deficiencies were identified during the survey. No further action is necessary concerning this report. Please retain this copy for your records.	Y 000		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE